

Week at a Glance Sleep Diary

Name:

DO THESE QUESTIONS BEFORE GETTING OUT OF HOME	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mean
Date								
Time to bed								
Minutes from bed to sleep (estimate – no clock watching)								
Number of arousals								
Minutes awake after first falling asleep (estimate)								
Total minutes out of bed (after initial falling asleep till final awakening – estimate)								
Reason for awakenings:								
SL								
TST								
DO THESE QUESTIONS BEFORE GETTING READY FOR BED								
Typical Day? (Yes/No)								
Fatigue level (poor 0 ---- 5 good)								
Stress Level (poor 0 ---- 5 good)								
Alertness (poor 0 ---- 5 good)								
Concentration Level (poor 0 ---- 5 good)								
Mood (poor 0 ---- 5 good)								
Time spent exercising (minutes)								
# of alcoholic beverages (1,2,3 etc.)								
Any sleeping pills/aids today? (Yes/No)								
Pain level before sleep (minimal 0 ----- 10 maximal)								
General health (felt fine 0 ----- 5 felt sick)								
Menstruation today (Yes/No) if applicable								
Menstrual Pain (minimal 0 ----- 10 maximal)								
Napping (No /Number of naps) N/1/2 ... etc.								
Nap start time								
Nap stop time								
Other Events								

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